STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G442		(X2) MULTIPL A. BUILDING B. WING	e construction 00	COM	TE SURVEY PLETED 06/2015	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	402	ET ADDRESS, CITY, STATE, ZIP EWING LN FERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CO	ORRECTION S SHOULD BE	(X5) COMPLETION DATE
W000000	Complaint #IN00 federal/state defit W149 and W157 This survey was a post certification full recertification survey. Dates of Survey: Facility Number Provider Number AIMS Number: Surveyor: Dotty The following festate findings in IAC 9.	done in conjunction with on revisit (PCR) to the on and state licensure February 5 and 6, 2015. 1000956 115G442 100244760 Walton, QIDP. deral deficiencies reflect accordance with 460 completed 2/19/15 by	W000000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLE	TED
15G442		B. WIN			02/06/2	2015	
NAME OF B	DOLUDED OD CLIDDLIED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				402 EW	/ING LN		
RES CARE COMMUNITY ALTERNATIVES SE IN			JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000149	483.420(d)(1) STAFF TREATME	ENT OF CLIENTS					
	•	evelop and implement					
		d procedures that prohibit					
	_	lect or abuse of the client.	1110	00140			02/00/2015
		review and interview for	WO	00149	149: 483.420(d)(1) STAFF TREATMENT OF CLIENTS		03/08/2015
		on reviewed, affecting 4					
	•	ents (A, B, C and D), the			TREATMENT OF CEIENT		
		ensure their policies					
		e and exploitation of					
clients by facility staff were		staff were			The facility must develop and	d	
	implemented. The facility failed to ensure				implement written policies a	nd	
	corrective action	(restitution for personal			procedures that prohibit		
	items) was comp	leted.			mistreatment, neglect or abu	se	
					of the clients.		
	Findings include	:			Convective Actions (Specific) As	_	
	-				Corrective Action: (Specific) An investigation was completed	n	
	Facility investiga	ations, incident reports			regarding the missing items of cli	ents	
	and Bureau of D	evelopmental			(A, B, C &D). Clinical Superviso		
		ices/BDDS reports since			will be in-serviced on the initiatir	ng	
		eviewed on 02/05/15 at			investigations and having them		
	2:30 PM and ind	dicated the following:			completed within 5 business days and the final investigation will be		
	An investigation completed on 1/13/15				sent to the Business Office Mana		
					and restitution for missing items	0	
	_	OS 1/08/15) by Clinical			were reimbursed and deposited in	ito	
	` 1	, •			the RFMS account. All staff wil	I .	
	Supervisor/CS #1 indicated some personal items of the clients had				in-serviced on the Abuse Neglect		
	•	e information was			Exploitation Policy and Procedur	es.	
	* *				How others will be identified:		
	-	/15 to House Manager #1			(Systemic) The Program Manag	ger	
	_	rted to the administrator.			will follow up with the Clinica		
	-	orted a Monopoly game			Supervisor at least weekly to		
		Christmas was missing.			ensure that all incidents that		
	-	l a pearl necklace and			require and investigation are		
		archased could not be			initiated and completed within	5	
	located.				business days. The Program		

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Event ID:

O4PZ11

Facility ID: 000956

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
15G442			B. WIN			02/06/2015		
NAME OF E	PROVIDER OR SUPPLIEF	· }		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
				402 EWING LN				
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX				PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)				
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	DATE		
	-	d she was missing an			Manager will ensure the Clinic			
	iPod and a gift c				Supervisor submits all finalize investigations to the Business	ed		
		d staff #2 had borrowed a			Office Manager to ensure fund	da da		
		use (valued at \$40.00)			are reimbursed to the clients.			
	and staff #2 had	not returned the items.			investigations will be provided			
					the Executive Director upon	110		
	The 1/13/15 invo	estigation indicated staff			completion for review.			
	#2 had "abandor	ned" her job on 1/02/15			completion for feview.			
	and would not re	eturn phone calls. The			Measures to be put in place:			
	investigation ind	licated the items were			Corrective Action: (Specific): A	An		
	_	out how it happened			investigation was completed			
	could not be determined.				regarding the missing items of cl			
		•••••			(A, B, C &D). Clinical Supervise will be in-serviced on the initiating			
	Δ follow-up RD	DS report dated 1/16/15			investigations and having them	ng		
	A follow-up BDDS report dated 1/16/15 indicated the missing items' value would				completed within 5 business days	s		
		_			and the final investigation will be			
	be found so the items could be replaced. The report indicated a police report				sent to the Business Office Mana			
	_				and restitution for missing items			
		been filed on the missing			were reimbursed and deposited in	l l		
		nad been no follow up by			the RFMS account. All staff wil			
	the police on the complaint as of 1/2				in-serviced on the Abuse Neglect Exploitation Policy and Procedur			
		70.114			Exploitation Folloy and Flocedul	C 5.		
		CS #1 on 2/06/15 at 3:00			Monitoring of Corrective Actio	on:		
		e valuation of the missing			The Program Manager will			
		nder investigation so the			follow up with the Clinical			
		ents A, B, C and D had			Supervisor at least weekly to			
	not been completed at the time of the				ensure that all incidents that			
	survey. The inte	rview indicated efforts			require and investigation are	_		
	had been made to contact staff #2 but they had failed. The interview indicated the facility's policy prohibited staff from borrowing clients' personal items regardless of their returning the items or				initiated and completed within	15		
					business days. The Program	,		
					Manager will ensure the Clinic			
					Supervisor submits all finalize	ea		
					investigations to the Business	da l		
	_	on to borrow. The			Office Manager to ensure fund			
		staff #2 had "abandoned"			are reimbursed to the clients.			
	linter view stated	DWII II Z IIUG UUUIIGUIIUG			investigations will be provided	ιω		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/09/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G442		(X2) MULTIPLE A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/06/2015	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREE	ET ADDRESS, CITY, STATE, ZIP EWING LN ERSONVILLE, IN 47130	CODE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION (X5) SHOULD BE COMPLETION APPROPRIATE DATE
	regarding the all #2 would have fa	fforts to reach her egations had failed. Staff aced disciplinary action uployed by the agency on their job are		the Executive Directo completion for review	7.
	and Procedure" of agency's 08/01/0 Procedure Manu was reviewed on The review indic prohibited abuse of clients. The downs as follows: "E. AbuseExp Definition: 1. An act that do real or personal pillegal means. 2. Utilization of selfish purposes.	neglect and exploitation efinition of exploitation loitation eprives an individual of property by fraudulent or another person for		Completion date: Ma	icu 6, 2015

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Event ID:

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE S	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPL	ETED	
15G442		B. WIN			02/06/	2015		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER		402 EWING LN					
RES CARE COMMUNITY ALTERNATIVES SE IN			JEFFERSONVILLE, IN 47130					
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX				PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
W000157	483.420(d)(4) STAFF TREATME	INT OF CLIENTS						
		tion is verified, appropriate						
	corrective action n							
	Based on record	review and interview for	W0	00157			03/08/2015	
	1 of 1 investigati	on reviewed, affecting 4			W157: 483.420(d)(4) STAFF			
		ents (A, B, C and D), the			TREATMENT OF CLIENTS			
	-	ensure corrective action			Tan 11			
		ersonal items) was			If the alleged violation is verified, appropriate corrective action must be taken.			
	completed.	crsonar rems) was						
	completed.				be taken.			
	Pinding ind 4.				Corrective Action: (Specific)	An		
	Findings include	:			investigation was completed			
					regarding the missing items of cli			
		ations, incident reports			(A, B, C &D). Clinical Superviso			
	and Bureau of D	evelopmental			will be in-serviced on the initiating	ng		
	Disabilities Serv	ices/BDDS reports since			investigations and having them			
	12/13/14 were re	eviewed on 02/05/15 at			completed within 5 business days and the final investigation will be			
	2:30 PM and indicated the following:				sent to the Business Office Mana			
		-			and restitution for missing items	501		
	An investigation	completed on 1/13/15			were reimbursed and deposited in	ito		
	_	OS 1/08/15) by Clinical			the RFMS account. All staff wil			
		1 indicated some			in-serviced on the Abuse Neglect			
	personal items of				Exploitation Policy and Procedur	es.		
	_	e information was			TT (1 '911 '1 ('6" 1			
	* *				How others will be identified:	~~*		
	•	/15 to House Manager #1			(Systemic) The Program Manag will follow up with the Clinica	-		
	•	rted to the administrator.			Supervisor at least weekly to	.1		
	-	orted a Monopoly game			ensure that all incidents that			
		Christmas was missing.			require and investigation are			
	-	d a pearl necklace and			initiated and completed within	5		
	earring set she pr	urchased could not be			business days. The Program			
	located.				Manager will ensure the Clinic	cal		
	Client C reported	d she was missing an			Supervisor submits all finalize			
	iPod and a gift ca				investigations to the Business	-		
		d staff #2 had borrowed a			Office Manager to ensure fund	ls		
	_	ise (valued at \$40.00)			are reimbursed to the clients. A			

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPLETED	
15G		15G442	B. WING			02/06/2015	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
RES CAR	RE COMMUNITY A	LTERNATIVES SE IN	402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	TE COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE	
	and staff #2 had	not returned the items.			investigations will be provided	l to	
					the Executive Director upon		
	The 1/13/15 invo	estigation indicated staff			completion for review.		
	#2 had "abandor	ned" her job on 1/02/15			Measures to be put in place:		
	and would not re	eturn phone calls. The			Corrective Action: (Specific): A	l n	
		licated how the items			investigation was completed	····	
		sing but how it happened			regarding the missing items of cli	ents	
	could not be dete				(A, B, C &D). Clinical Superviso		
					will be in-serviced on the initiatir	ıg	
	A follow up DD	DC report dated 1/16/15			investigations and having them		
	1	DS report dated 1/16/15			completed within 5 business days		
	indicated the missing items' value would				and the final investigation will be		
	be found so the	items could be replaced.			sent to the Business Office Mana	ger	
					and restitution for missing items were reimbursed and deposited in	nto.	
	Interview with CS #1 on 2/06/15 at 3:00 PM indicated the valuation of the missing				the RFMS account. All staff wil		
					in-serviced on the Abuse Neglect		
	items was still u	nder investigation so the			Exploitation Policy and Procedur		
	restitution to clients A, B, C and D had				•		
		eted at the time of the			Monitoring of Corrective Action	1:	
	survey.				The Program Manager will		
	Survey.				follow up with the Clinical		
	TP1. in C. 1 1.4	malada a da Cananala ind			Supervisor at least weekly to		
	_	relates to Complaint			ensure that all incidents that		
	#IN00162588.				require and investigation are		
					initiated and completed within	. 5	
	9-3-2(a)				business days. The Program		
					Manager will ensure the Clinic	cal	
					Supervisor submits all finalize	d	
					investigations to the Business		
					Office Manager to ensure fund	I	
					are reimbursed to the clients. A		
					investigations will be provided	l to	
					the Executive Director upon		
					completion for review.		
					•		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/06/2015	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
				Corrective Action Date: Ma 8, 2015	arch	

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Event ID:

O4PZ11

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